Palliative Care Initiative in Older Adults Diagnosed with Cancer

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Introduction

Older adults with cancer do not have sufficient access to palliative care services in the outpatient setting resulting in poorer quality of life (QOL). Consequential to knowledge deficits regarding the purpose and role of palliative care, palliative care referrals are placed late in the disease trajectory further decreasing patient access to care and QOL. Individuals with an oncological diagnosis experience an array of symptoms secondary to the nature of their disease and/or its treatments. These symptoms are often poorly managed due to lack of care coordination, which can result in further complications or hasten death [1]. Earlier referrals to palliative care in the community for cancer patients can lead to increased QOL, decreased health related expenses and decrease in aggressive end-of-life treatment [2,3].

Purpose

The purpose of this quality improvement (QI) project was to increase patient knowledge and acceptance of palliative care, increase patient satisfaction with care and improve the quality of life (QOL) of cancer patients through the development of a clear clinical pathway within one organization..

Aims

- To determine the effects of a palliative care education program specific for symptom management and enhanced quality of life on patient knowledge as measured by PaCKS pre-test and post-test questionnaires administered at the educational sessions.

- To determine the effects of a palliative care education program specific for symptom management and enhanced quality of life on acceptance of palliative care as measured by PCPS pre-post test.

- To determine the effect of a CCPRS program on the QOL and patient satisfaction with care of newly diagnosed (within 8 weeks of diagnosis) cancer patients as measured by the FACIT-G & FACIT-TS-PS tools at baseline and again after approximately a 12-week period.

Methods

Pre/post design QI in the South-Atlantic Region of the U.S.A.. Convenience samples for the education (n= 8) and palliative integration (n= 12) interventions consisted of persons enrolled at the organization of interest aged 65 or older with a cancer diagnosed within 8 weeks of initial palliative care consult.

Measures

Clinical Intervention
- QOL: FACIT-G - 27 item questionnaire
- Patient satisfaction with care: FACIT-TS-PS – 29 item questionnaire

Educational Intervention
- Patient knowledge of palliative care: PaCKS – 13 item questionnaire.
- Patient preference for palliative care: PCPS – 14 item questionnaire.

Sample

Two convenience samples – all Spanish native-speaking Hispanics

Inclusion criteria:
- **Clinical intervention (recruited via referrals); n= 12**
    - 65+ years old
    - New cancer diagnosis followed by oncologist
    - Any cancer at any stage
- **Educational intervention(recruited at chemotherapy centers); n = 8**
    - 65+ years old
    - Receiving long infusion at chemotherapy center

Table 1a

Clinical Intervention Demographics for enrolled participants

Demographics	n (%) 12 (100%)
Sex	
Female	10 (83.3%)
Male	2 (16.7%)
Country of Origin	
Nicaragua	2 (16.7%)
Cuba	7 (58.3%)
Panama	1 (8.3%)
Dominican Republic	1 (8.3%)
Guatemala	1 (8.3%)
Does patient have family/social support?	
Yes	11 (91.7%)
No	1 (8.3%)
Is there an Advanced Directive (AD) on record at baseline?	
No	12 (100%)

Table 1b

Educational Intervention Demographics

Demographics	n (%) 8(100%)
Sex	
Female	1 (12.5%)
Male	7 (87.5%)
Is there an Advanced Directive (AD) on record at baseline?	
No	8 (100%)

Interventions

Educational intervention:
- Provided one-time live educational evidence-based 15-minute lecture sessions produced by Palliative Care (PC) APRN in Spanish.
- Individuals were administered written Spanish translated validated questionnaires (PaCKS and PCPS) prior to the intervention and immediately after.

Clinical Intervention:
- Recruited individuals earlier in the cancer disease trajectory (within 8 weeks of initial diagnosis) through the Care Coordination Palliative Referral System (CCPRS).
- The program had a PC team evaluating individual's needs and coordinating/placing appropriate referrals according to the evaluations.
- Written Spanish validated (FACIT-TS-PS & FACIT-G) tests were administered at baseline and then again at 12 weeks.

Results

The project found that with the educational intervention there was an increase in knowledge of palliative care (p=0.027) despite not increasing preference for palliative care (p=0.611). The clinical intervention found that participants were more satisfied with their care (p=0.038) despite no significant improvements in their QOL (p=1.000).

Educational Intervention (n=8)

	Palliative Care Knowledge Scale (PaCKS)		Palliative Care Preferences Scale (PCPS)	
	Median	P-value	Median	P-value
Pre-Test	6.50	0.027	58.00	0.611
Post-Test	11.00		61.00	

Table 2. The Palliative Care Knowledge Scale (PaCKS) possible range of scores is 0-13. Higher scores indicate higher knowledge of palliative care. The possible range of values for total Palliative Care Preferences Scale (PCPS) score is 14-93 for patients in the educational intervention. Higher scores indicate higher preference for palliative care. Both tools were used to test the same group (n=8). They were tested immediately before a brief lecture presentation on palliative care and immediately after the lecture. Pre/Post data were compared to determine the effect of the intervention. All tools were approved for Spanish translation. Lecture material was presented in Spanish as this is the primary language identified for this population. P-value significant at P<0.05 – calculated using Wilcoxon Signed Rank Test.

Clinical Intervention (n=9- paired data)

	Functional Assessment of Cancer Therapy Treatment Patient Satisfaction (FACIT-TS-PS)				Functional Assessment of Cancer Therapy Treatment General (FACIT-G)			
	Median	IQR		P-Value	Median	IQR		P-Value
		Q1 (25%)	Q3 (75%)			Q1 (25%)	Q3 (75%)	
Pre-Test	63.50	45.50	65.75	0.038	72.50	62.00	94.75	1.000
Post-Test	78.00	63.50	78.00		74.00	70.50	81.00	

Table 3. The Functional Assessment of Cancer Therapy Treatment Patient Satisfaction (FACIT-TS-PS) possible range of scores is 0-78. Higher scores indicate higher satisfaction with care. The possible range of values for total Functional Assessment of Cancer Therapy General (FACIT-G) score is 0-108 for persons in the clinical intervention. Higher scores indicate higher quality of life (QOL). Both tools were used to test the same group (n=9). They were tested at baseline and again at 3- months after initial intervention. Pre/Post data were compared to determine the effect of the intervention. Initially 12 participants were recorded for pre-test data and only 9 for post test data due to attrition. The Wilcoxon Ranked Signed Test was used to analyze only paired data for the 9 individuals.

Conclusions

The project demonstrated the positive impact earlier implementation of palliative care could have on overall satisfaction with care. The project also found that palliative care education increases participant knowledge of palliative care and helped de-stigmatize end-of-life care for this culturally homogenous population.

Discussion

This project's educational intervention concentrated on educating older adults with cancer and it improved member knowledge of palliative care despite not improving preference. These results support that the educational intervention successfully increased knowledge of palliative care in participants. The increase in knowledge for participants of the project helped nurture stakeholder buy-in for additional educational seminars for the entire member population. Increasing members' knowledge of palliative care may help de-stigmatize these services within the organization and eventually affect member preferences for palliative care.

Medicare incentivizes member satisfaction with care through the Medicare Advantage funds. The clinical CCPRS intervention showed that palliative care increased participant satisfaction with their care despite any negative changes in QOL or disease progression. The organization has been able to recognize the positive impact that early palliative care has had on participants of this project and their satisfaction with care. Stakeholders may now be willing to re-invest these additional funds to help ensure the sustainability and growth of CCPRS.

The CCPRS has been able to clinically demonstrate its significance for the organization by addressing symptoms periodically and earlier in comparison to how symptom recognition and management had been previously accomplished. The program has increased the amount of appropriate hospice referrals by identifying individuals who qualify for these programs earlier in their disease and helping de-stigmatize hospice through education. This has resulted in significant cost-savings for the organization, where now hospice funds can be allocated to focus on QOL rather than the continuation of non-curative aggressive treatments.

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